SOUTH DAKOTA HEALTH PROFESSIONALS ASSISTANCE PROGRAM
4400 WEST 69TH STREET #600 ◆ SIOUX FALLS SD 57108
TEL: (605) 310-2426 FAX: (605) 322-4060

PARTICIPANT SELF-REPORT FORM
DUE BY THE 7TH OF EACH MONTH

NAME: _____ TELEPHONE: _____

CURRENT ADDRESS: _____

REPORTING PERIOD: _____ REPORT DATE: _____

CURRENT WORK SITE: _____

JOB TITLE: _____ WORK TEL: _____

WORK SITE ADDRESS: _____

SHIFTS WORKED: ❒ DAY ❒ EVENING ❒ NIGHT

HOURS WORKED THIS PERIOD: _____

1. Please share any accomplishments, successes, or positive learning experiences during this reporting period, including length of sobriety.

2. During this period, were you able to completely abstain from the use of alcohol?
   ❒YES ❒NO
   If NO, please provide date(s) of use and circumstances related to use.

3. During this period, were you able to completely abstain from use of any non-prescribed, controlled, and/or illicit substances?
   ❒YES ❒NO
   If NO, please provide date(s) of use and circumstances related to use.

4. Please list all substances used during this reporting period (include prescriptions by a physician or dentist, and any over-the-counter medications).

5. Are you attending ❒AA ❒NA groups per recommendation of your monitoring contract?
   ❒YES ❒NO Please list number of meetings attended per week: _____

6. Are you attending therapy sessions and physician and psychiatry appointments per recommendation of your monitoring contract?
   ❒YES ❒NO
   Please list number of appointments for each during this reporting period: _____

   _____

   If you have not complied with services per your monitoring contract, please state why:

7. Please share any other problems or concerns that you may have experienced over the past reporting period, including work-related, school-related, relationship, spiritual, physical health/illnesses, and/or concerns related to recreation or leisure time.

MONTHLY MEDICATION LOG

Please list all narcotic, amphetamine, sedative, or benzodiazepine medications used during this reporting period (including prescription or over-the-counter medications) using additional sheets of paper if needed:

MEDICATION: _____

Amount Prescribed: _____ Date Prescribed: _____

Dates Used in the Past Month: _____

_____

Amount Remaining: _____

MEDICATION: _____

Amount Prescribed: _____ Date Prescribed: _____

Dates Used in the Past Month: _____

_____

Amount Remaining: _____

MEDICATION: _____

Amount Prescribed: _____ Date Prescribed: _____

Dates Used in the Past Month: _____

_____

Amount Remaining: _____

MEDICATION: _____

Amount Prescribed: _____ Date Prescribed: _____

Dates Used in the Past Month: _____

_____

Amount Remaining: _____